and economic costs of ADHD are not well understood. We sought to examine the impact of childhood ADHD on caregivers' work status and work productivity, and patients' health care use. **METHODS:** We conducted a telephone survey of 154 caregivers of ADHD-diagnosed children. Caregivers were identified from membership in CHADD (Children and Adults with Attention-Deficit/Hyperactivity Disorder). **RESULTS:** The mean number of ADHD-diagnosed children per caregiver was 1.3 (range 1–4); 60% of children were in 6th grade or lower. The reported mean number of prior year ADHD-related visits to pediatricians, psychiatrists, psychologists, and counselors was 2.0, 3.7, 2.9, and 6.6 visits, respectively. In the 3 months prior to telephone survey, 18% of visits were for unscheduled emergencies—63% of caregivers reported some change in their work status as a result of their child's ADHD. Of these, 15% changed type of job, 46% reduced hours worked per week, and 11% stopped working completely. During the 4 weeks prior to survey, caregivers reported having lost an average of 0.8 days from work and being 25% less productive, for an average of 2.4 days attributed to their child's ADHD—this is equivalent to 39 days reduced caregiver productivity per year. **CONCLUSIONS:** Childhood ADHD adversely affects caregiver work status and work productivity. ADHD also results in frequent unscheduled emergency visits. Effective disease management of childhood ADHD may ultimately mitigate substantial costs borne by employers and health care systems.

PMH11

SCHIZOPHRENIA CARE AND ASSESSMENT PROGRAM (SCAP): THE IMPACT OF CLINICAL SYNDROME, ANTIPSYCHOTIC MEDICATION TREATMENT AND ADHERENCE ON OUTPATIENT PSYCHIATRIC UTILIZATION

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OBJECTIVE: To examine the impact of clinical syndrome, type of medication and adherence on outpatient utilization. **METHODS:** Baseline data predicted 6-month outpatient utilization (n = 985). Psychotherapy, clinic visits (specimen collection), and total number of outpatient visits were examined. Presence of medication (15 first-generation; 5 novel; both) was coded. Adherence reflected the 4-weeks prior to assessment. Clinical syndrome variables: deficit, hallucinations/delusions, and disorganization. Negative binomial regression (adjusted standard errors). **RESULTS:** Psychotherapy Visits: Positive effect observed for higher hallucinations/delusions and use of both first- and second-generations. Clinic Visits: The probability of visit was positively impacted by higher disorganization, adherence, education less than high school graduation, and CHAMPUS. Negative effect noted for use of novel agents and having Medicare only. Number of visits higher for those with higher disorganization. Total Outpatient Visits: Positive effect observed for adherence at both periods and treatment with novel agents alone or in combination with first-generation agents. The clinical syndrome variables did not achieve significance. **CONCLUSIONS:** The positive correlation of medication adherence at both baseline and 6 months with clinic visits and total visits is an important driver in outpatient services utilization. The type of medication positively impacts the number of visits, however, a negative association was observed between type of medication and the probability of a clinic visit. It may be possible that some persons using novel agents achieve improvement through outpatient medication management (psychotherapy visits) and may require less frequent clinic visits (for specimen collection), suggesting that the favorable adverse event profile of second-generation agents may promote community functioning. Positive symptoms and disorganization drive the occurrence and number of visits while the presence of deficit syndrome did not achieve significance. These findings suggest that as treatment costs vary by method, payers could benefit by assessing clinical syndrome in order to estimate disease-related payments accurately.

PMH12

PREVALENCE OF COMORBID ANXIETY AND DEPRESSION AMONG PATIENTS PRESCRIBED SSRI MONOTHERAPY

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OBJECTIVE: To examine the distribution of mental health conditions comorbid to depression, especially anxiety, among patients treated for 1–6 months or 7–12 months with an SSRI. **METHODS:** The study comprised a retrospective review of integrated medical and pharmacy claims from a national managed care organization. Continuously enrolled patients between the ages of 18 and 65 years were identified from the 1.9M claims underlying six IPA model plans for 1997–1998. Patients placed on SSRI therapy following a 4 month period without drugs were stratified according to underlying mental health conditions and length of SSRI monotherapy. **RESULTS:** Overall, between 47% and 52% of patients placed on SSRI monotherapy had a history of depression; an additional 5–12% had histories of anxiety without depression. Greater proportions of patients for whom paroxetine was prescribed rather than either fluoxetine or sertraline had anxiety comorbid to depression in the year prior to initiating drug therapy(11.5%, 6.5%, 7.9%, respectively)(Chi-square $<.001$). The 40 or more percent of patients without depression or anxiety in their histories—12 months preceding initiation of drug therapy and month of initiation—but treated with SSRIs often had diagnoses for other mental health conditions, specifically neurotic disorders, affective psychoses, nondependent abuse of drugs and adjustment reaction. These diagnoses patterns persisted when patients were subset according to persistence of therapy, i.e., SSRI therapy for greater or